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September 28, 2011

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Madame Secretary:

On behalf of the State of Nevada's Healthcare Reform Planning Group, we write to comment on proposed rules regarding the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment published in the Federal Register on July 15 in accordance with title I of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act (ACA).

We appreciate the opportunity to comment on this important regulation and are generally pleased with the proposed rule. We applaud the flexibility that the regulations allow the State in selecting an applicable reinsurance entity. However, in the spirit of State-federal partnership, we have several suggestions regarding ways in which we believe the regulation could be improved to help ensure that onerous burdens are not placed on States or carriers and that these risk mitigation strategies achieve the desired goals of mitigating the impact of potential adverse selection and of stabilizing premiums in the individual and small group markets as insurance reforms and the Affordable Health Insurance Exchanges ("Exchanges") are implemented, starting in 2014. Additionally, we believe that flexibility is a crucial component of implementation of the ACA, and we applaud the flexibility the proposed rule provides. However, we have noted several areas where we believe that greater flexibility is warranted.

Definitions (§153.20):
Section 153.20 defines a contributing entity with respect to the reinsurance program as "any health insurance issuer and, in the case of a self-insured group health plan, the third

party administrator of the group health plan". We believe that the responsibility for making the reinsurance contributions should be placed on the risk-bearing entity. While the insurer is the risk-bearing entity for fully insured plans, the employer, not the administrator, is the risk-bearing entity for self-insured plans. By defining the contributing entity as the administrator of the self-insured plan, it appears that the responsibility has been inappropriately shifted from the employer to the administrator. Therefore, we suggest that the definition of a contributing entity be revised to correctly identify the employer as the risk-bearing entity.

Definitions (§153.200):

Pursuant to §153.200, the definitions of reinsurance parameters (coinsurance rate, reinsurance cap and attachment point) are all tied to the costs associated with the essential health benefits package as described in section 1302(b) of the ACA. This means that all reinsurance payments will be based on the essential health benefits package, regardless of the actual benefits covered. We believe that this requirement will add an unnecessary administrative burden on issuers who will have to separately track the claims arising from essential health benefits. Since the transitional reinsurance program is temporary, the additional expense needed to change computer systems in order to extract the appropriate data does not appear to be commensurate with the benefits of this temporary program. Therefore, basing the reinsurance parameters on the essential health benefits package may be in conflict with one of the three critical policy goals of the transitional reinsurance program as stated on page 16 of the preamble to the regulation. Additionally, the use of the essential health benefits as the basis for reinsurance payments could have unintended consequences on the individual market if a State-mandated benefit is not included in the essential health benefits package. Therefore, we recommend that reinsurance payments made under this program be based on total claims payments rather than on claims arising solely from benefits provided under the essential health benefits package.

Pursuant to §153.200 and §153.220, reinsurance contributions are based on a percentage of earned premiums for fully insured plans and on a percentage of medical expenses for self-insured plans. This proposed definition results in higher contributions for insured plans, compared to similar self-insured plans because it includes administrative expenses in the contribution base for fully insured health plans but not for self-insured health plans. We do not think it is necessary to have completely different rules for determining reinsurance contributions for self-funded plans as compared to fully insured plans. We therefore recommend that contributions for self-insured plans be based on the premium-equivalent (which is routinely calculated by self-insured plans to reflect the anticipated cost of claims and administrative costs) rather than on medical expenses to ensure that both fully insured and self-insured plans are treated equitably.

State establishment of a reinsurance program (§153.210):

§153.210(a) provides that each State that elects to operate an Exchange must establish a reinsurance program for the years 2014 through 2016. We ask that you consider allowing all States the flexibility to choose to operate the transitional reinsurance program or have

it operated by HHS, just as you have proposed for the administration of the risk adjustment program.

Additionally, pursuant to 155.106, States may elect to establish an Exchange after 2014. However, it appears that even if a State defers the operational date of the Exchange, the mere act of electing to operate an Exchange means that a State will be committed to establishing a reinsurance program starting in 2014. This seems to be an unreasonable burden on those States that make the election to defer the operation of the Exchange. At a minimum, during the period a State is not administering its own Exchange, States should be afforded the same flexibility as those States that decide not to administer an Exchange.

Collection of Reinsurance Contributions (§153.220):
In response to the request for comments regarding the basis for calculating the reinsurance contribution, we agree that a national contribution rate using the percent of premium method is the fairest and administratively simplest way to collect contributions.

§153.220(b)(2)(i) indicates that reinsurance payments must be used for reinsurance payments. Additionally, §153.220(3) provides that an applicable reinsurance entity may collect more than the amounts due from the set national rate to provide funding for administrative expenses of the applicable reinsurance entity. This appears to indicate that contributions collected based on the national contribution rate cannot be used to pay administrative expenses. Please clarify the intent of these provisions which seem to imply that each State will have to fund the administrative costs of the transitional reinsurance program from sources other than the federally mandated contribution.

If, in fact, national reinsurance contributions cannot be used to support the administrative expenses of a State-based reinsurance program, we respectfully request reconsideration of this funding restriction. As you know, States, in general, and Nevada, in particular, are under extreme financial stress. We can ill afford to establish and fund any new programs. Again, since the proposed rule allows those States that choose not to administer an Exchange to also defer administration of their reinsurance program, we are concerned that this funding restriction constitutes an unfunded mandate on those States that choose to operate (and fund) an Exchange. This provision of the proposed rule may have the unintended consequence of pushing more States into the federal default on the Exchange.

We urge you to reconsider, and we suggest that you develop a funding mechanism for administrative expenses through the national reinsurance contributions.

§153.220(a) requires States to ensure that the applicable reinsurance entity collects the required contributions from the contributing entities. However, States do not have enforcement authority over self-insured employers or their third-party administrators to ensure that these entities make the required contributions. We would therefore like clarification of the jurisdictional authority at either the State or federal level to ensure compliance by employers providing self-insured plans to their employees.

Disbursement of Reinsurance Payments (§153.240):
In response to the request for comments regarding the timing of reinsurance payments, we believe that, due to the unique market circumstances that exist in each jurisdiction, States should be given as much flexibility as possible in setting timeframes for reinsurance entities to pay claims.

Additionally, States should be allowed the flexibility to use a methodology that ensures that all claims are paid on a uniform proportional basis rather than reward carriers on a first-come first-served basis. For example, a State may decide to pay an initial stated percentage of all eligible claims to ensure that all carriers are treated fairly and that payments are not unfairly made to those issuers that present claims first. If there are any left over funds at the end of a reasonable period (e.g., quarter or year), a State may then increase the percentage of all claims paid. The methodology employed by the State should be clearly described and all reinsurance-eligible plans should be provided with advance notification of the methodology.

We also request that you clarify the timing of the application of reinsurance, risk corridor and risk adjustment calculations and payments as these programs apply to the determination of the medical loss ratio (MLR). Additional guidance with regard to the schedule/timing of each of these programs is respectfully requested.

§153.250(c) requires that a State maintain books, records, documents, and other evidence of accounting procedures and practices of the reinsurance program for each benefit year for at least 10 years. This exceeds Nevada's record retention requirements. Therefore, we request that the record retention period be reduced to 5 years or the State's record retention period, if longer. Additionally, this provision of the regulation indicates that it is the State's responsibility to maintain such records. Since the temporary reinsurance entity is expected to dissolve after the program ends, requiring the reinsurance entity to be maintained just for the purpose of being the custodian for the records would be an unnecessary and costly administrative burden. Therefore, in addition to reducing the 10 year record retention requirement, we suggest that the regulation clarify that another State entity such as the State insurance department be allowed to maintain the records.

Risk adjustment administration (§153.310):
Pursuant to §153.310, a State may elect to have an entity other than the Exchange perform the risk adjustment functions provided that the entity selected meets the requirements proposed in §155.110 of the notice of proposed rulemaking entitled, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," published on July 15, 2011.

We believe that requiring States to adhere to the conflict of interest and other governance restrictions applicable to Exchanges imposes an unnecessary administrative burden on the States. While the limitations placed on the governing structure of Exchanges may be considered appropriate, it is not appropriate for the risk adjustment program, which we believe to be a more technical program that does not require the same breadth of participation and oversight.

Additionally, some States may want the flexibility to use one entity to administer both the transitional reinsurance program and the risk adjustment program. As stated, §153.310 requires States that want to combine the administration of the two programs to comply with the restrictions of §155.110 for both programs. We believe that this will impede the effectiveness of both programs.

Finally, we suggest that State insurance departments be included in the list of entities eligible to administer risk adjustment programs.

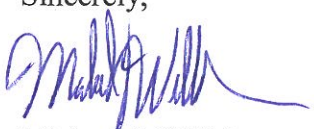
Data Collection under risk adjustment (§153.340):
§153.340(c) provides that any State with an all payer claims database that is operational on or before January 1, 2013 may request an exemption from the data collection minimum standards. It is not clear how this exemption will apply to States that receive a conditional approval or that elect to defer the establishment of an Exchange beyond January 1, 2014 in accordance with §155.105 and §155.106, respectively.

Risk Adjustment Issuer Requirements (§153.610):

§153.610 requires that plans provide all required information necessary for risk adjustment of covered plans. However, this and related sections of the proposed regulations seem to suggest that states should have the authority to collect additional data necessary for rate review and trend analysis, all necessary functions for appropriate risk adjustment. If the proposed regulation intends to provide states that use or intend to use an all-payer claims database the authority to require plans to submit data necessary to satisfy the requirements for use of such a database, the rules should explicitly provide states with that authority.

We appreciate the opportunity to offer these comments, and look forward to working with you further on these and other health care reform implementation activities. Thank you very much for considering our input.

Sincerely,



Michael J. Willden
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Acting Executive Director, Silver State Health Insurance Exchange

cc: Ann Wilkinson, Deputy Chief of Staff, Office of the Governor
Terry Johnson, Director, Department of Business and Industry
Amy Parks, Acting Insurance Commissioner, Division of Insurance
Chuck Duarte, Administrator, Division of Health Care Financing and Policy